

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07736

1. PLACE OF DEATH a. COUNTY <i>Cabret</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Cabret</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Union Frederick</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret County Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>FLORENCE M. BARNES</i>		4. DATE OF DEATH Month Day Year <i>July 26, 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 16, 1883</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>Abraham Monnett</i>		14. MOTHER'S MAIDEN NAME <i>Oletha Stinnett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <i>No</i> (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT Address <i>James Barnes - Bromes Island, Ind</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ureidic</i> <i>420.1</i> DUE TO <i>Coronary Thrombosis &amp; myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic atherosclerosis</i> (c) <i>Chronic atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 20, 1961</i> to <i>July 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 20, 1961</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>R. E. Villars</i>		22b. DATE SIGNED <i>7/28/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. E. Villars</i>		22d. ADDRESS <i>5 The on ord</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 29, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Watson Memorial Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Ind</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. G. Harkness</i>		25a. REC'D BY REGISTRAR <i>Aug 1 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

12

1  
B  
M  
064  
I

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7746  
CERTIFICATE OF DEATH

07737

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Barnes C. Bowen</u>				4. DATE OF DEATH <u>July 30 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Buckler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>217-36-5380</u>			
17. INFORMANT <u>Leroy A. Bowen, Prince Frederick Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation &amp; Edema</u> 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>Rheumatoid Arthritis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>July 30, 1961</u> , that (I) (we) lost the deceased alive on <u>July 29, 1961</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Page C. Jett</u> M.D.				22b. DATE SIGNED <u>7/31/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>				22d. ADDRESS <u>PRINCE FREDERICK, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 1, 1961</u>		<u>Asbury Cemetery</u>		<u>Barstow Calvert Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness Son, Natural, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 2 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>			

MEDICAL CERTIFICATION

1773

CERTIFICATE OF DEATH

1773

(M)

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7747

07738

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barstow</u> c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barstow (Rural)</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>W.</u> Last <u>Bowen</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1879</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		9b. AGE (In years, last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Calvert Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Virginia Padden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-366594</u>	
17. INFORMANT <u>Kenneth D Bowen, Prince Frederick Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fidiotism (Uremia)</u> 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2, 1959</u> to <u>7/15/61</u> , that (I) (we) last saw the deceased alive on <u>7/15/61</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Pepe J. St</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Dr. J. J. St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 17, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Barstow Calvert Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.A. Harkness Son, Mutual Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>		25c. REGISTRAR'S SIGNATURE	

38778

1947

(M)

(1)



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7748

Item 1, File # 306 2/5/62 cas

Reg. Dist. No. 07739

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) <u>7 Beach</u> c. LENGTH OF STAY IN 1b <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1st + Erie</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7 Beach</u> d. STREET ADDRESS <u>1st + Erie</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Hoover</u> Last <u>Hoover</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11 Jan 1910</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Construction work</u>	
11c. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-16-0835</u>	
17. INFORMANT <u>Neibert Hoover</u> Address <u>7 Beach Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>                    </u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. J. Weems</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. J. Weems</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 26, 1961</u>		22b. DATE THEREOF <u>July 26, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brohick Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lorton Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u>		ADDRESS <u>Clwings Md.</u>	
24a. REC'D BY REGISTRAR <u>                    </u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>JUL 27 61</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

1  
B  
M  
064  
1  
0

7749

7749

CERTIFICATE OF DEATH

07740

1. PLACE OF DEATH  
a. COUNTY  
Calvert  
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
o. STATE  
Maryland  
b. COUNTY  
Calvert

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Prince Frederick

c. LENGTH OF STAY IN 1b  
3 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Randall Cliffs

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION  
Calvert County Hospital

d. STREET ADDRESS  
1

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)  
First Middle Last  
Mildred Irene Johns

4. DATE OF DEATH  
Month Day Year  
July 23 19 61

5. SEX  
Female

6. COLOR OR RACE  
white

7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH  
5/13/1901

9. AGE (In years last birthday)  
60 yrs.

IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10b. KIND OF BUSINESS OR INDUSTRY  
Own Home

11. BIRTHPLACE (State or foreign country)  
Michigan

12. CITIZEN OF WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME  
Noah Wilson Welch

14. MOTHER'S MAIDEN NAME  
Jennie Mae McCourte Wilcox

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
No

16. SOCIAL SECURITY NO.  
(If yes, give war or dates of service)  
220-07-8107

17. INFORMANT  
Address  
James Johns Randall Cliffs, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebral accident (stroke)  
331 X DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour o. m. p. m.  
Month Day Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/10/1959 to 7/22, 1961 that (I) (we) lost saw the deceased alive on 7/22 1961 and that death occurred at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE  
Dr. Weems, M.D.

22b. DATE SIGNED  
7/23/61

22c. PHYSICIAN'S NAME (Type)  
Dr. Weems, M.D.

22d. ADDRESS  
c/o Calvert County Hospital  
Prince Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

23b. DATE THEREOF  
7/26/61

23c. NAME OF CEMETERY OR CREMATORY  
Arlington Natl Cem.

23d. LOCATION (City, town, or county) (State)  
Ft. Myer Va.

24. FUNERAL DIRECTOR'S SIGNATURE  
ADDRESS  
Ritchie Bros. Fun'l Home-Upper Marlboro, Md.

25a. REC'D BY REGISTRAR  
DATE  
AUG 27 '61

25b. REGISTRAR'S SIGNATURE  
Arthur S. Kraus

CERTIFICATE OF DEATH

1918

STATE OF NEW YORK

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date of death on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7750

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07741

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> c. LENGTH OF STAY IN 1b <u>7</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EDWARD C. LICHTENBERGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cabot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward C. Lichtenberger</u> First Middle Last 4. DATE OF DEATH <u>7</u> Month <u>14</u> Day <u>1961</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/29/95</u> 9. AGE (In years, months, and days) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nav. Yard</u> 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George M. Lichtenberger</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Klinebinst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Mary Sueeth - 1112 N. Geo. St., York, Pa.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>782.4</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>found dead in home where he lived</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u>7</u> p. m. <u>14</u> 19 <u>61</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. City or town <u>Island Creek</u> (County) <u>Cabot</u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) <u>H. W. WARD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/14/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7/18/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u> 22d. LOCATION (City, town, or county) <u>York, Pa.</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son - Mutual, Ind.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>JUL 18 '61</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>10/15/1960</i>		6. TIME OF DEATH <i>10:00 AM</i>		7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <i>Natural</i>		10. MEDICAL HISTORY <i>None</i>		11. PRESENT ILLNESS <i>None</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF JURY <i>[Signature]</i>		16. SIGNATURE OF CORONER <i>[Signature]</i>	
17. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		18. SIGNATURE OF JURY <i>[Signature]</i>		19. SIGNATURE OF CORONER <i>[Signature]</i>		20. SIGNATURE OF WITNESS <i>[Signature]</i>	
21. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		22. SIGNATURE OF WITNESS <i>[Signature]</i>		23. SIGNATURE OF JURY <i>[Signature]</i>		24. SIGNATURE OF CORONER <i>[Signature]</i>	
25. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		26. SIGNATURE OF JURY <i>[Signature]</i>		27. SIGNATURE OF CORONER <i>[Signature]</i>		28. SIGNATURE OF WITNESS <i>[Signature]</i>	
29. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		30. SIGNATURE OF WITNESS <i>[Signature]</i>		31. SIGNATURE OF JURY <i>[Signature]</i>		32. SIGNATURE OF CORONER <i>[Signature]</i>	
33. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		34. SIGNATURE OF JURY <i>[Signature]</i>		35. SIGNATURE OF CORONER <i>[Signature]</i>		36. SIGNATURE OF WITNESS <i>[Signature]</i>	
37. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		38. SIGNATURE OF WITNESS <i>[Signature]</i>		39. SIGNATURE OF JURY <i>[Signature]</i>		40. SIGNATURE OF CORONER <i>[Signature]</i>	
41. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		42. SIGNATURE OF JURY <i>[Signature]</i>		43. SIGNATURE OF CORONER <i>[Signature]</i>		44. SIGNATURE OF WITNESS <i>[Signature]</i>	
45. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		46. SIGNATURE OF WITNESS <i>[Signature]</i>		47. SIGNATURE OF JURY <i>[Signature]</i>		48. SIGNATURE OF CORONER <i>[Signature]</i>	
49. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		50. SIGNATURE OF JURY <i>[Signature]</i>		51. SIGNATURE OF CORONER <i>[Signature]</i>		52. SIGNATURE OF WITNESS <i>[Signature]</i>	
53. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		54. SIGNATURE OF WITNESS <i>[Signature]</i>		55. SIGNATURE OF JURY <i>[Signature]</i>		56. SIGNATURE OF CORONER <i>[Signature]</i>	
57. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		58. SIGNATURE OF JURY <i>[Signature]</i>		59. SIGNATURE OF CORONER <i>[Signature]</i>		60. SIGNATURE OF WITNESS <i>[Signature]</i>	
61. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		62. SIGNATURE OF WITNESS <i>[Signature]</i>		63. SIGNATURE OF JURY <i>[Signature]</i>		64. SIGNATURE OF CORONER <i>[Signature]</i>	
65. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		66. SIGNATURE OF JURY <i>[Signature]</i>		67. SIGNATURE OF CORONER <i>[Signature]</i>		68. SIGNATURE OF WITNESS <i>[Signature]</i>	
69. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		70. SIGNATURE OF WITNESS <i>[Signature]</i>		71. SIGNATURE OF JURY <i>[Signature]</i>		72. SIGNATURE OF CORONER <i>[Signature]</i>	
73. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		74. SIGNATURE OF JURY <i>[Signature]</i>		75. SIGNATURE OF CORONER <i>[Signature]</i>		76. SIGNATURE OF WITNESS <i>[Signature]</i>	
77. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		78. SIGNATURE OF WITNESS <i>[Signature]</i>		79. SIGNATURE OF JURY <i>[Signature]</i>		80. SIGNATURE OF CORONER <i>[Signature]</i>	
81. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		82. SIGNATURE OF JURY <i>[Signature]</i>		83. SIGNATURE OF CORONER <i>[Signature]</i>		84. SIGNATURE OF WITNESS <i>[Signature]</i>	
85. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		86. SIGNATURE OF WITNESS <i>[Signature]</i>		87. SIGNATURE OF JURY <i>[Signature]</i>		88. SIGNATURE OF CORONER <i>[Signature]</i>	
89. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		90. SIGNATURE OF JURY <i>[Signature]</i>		91. SIGNATURE OF CORONER <i>[Signature]</i>		92. SIGNATURE OF WITNESS <i>[Signature]</i>	
93. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		94. SIGNATURE OF WITNESS <i>[Signature]</i>		95. SIGNATURE OF JURY <i>[Signature]</i>		96. SIGNATURE OF CORONER <i>[Signature]</i>	
97. SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		98. SIGNATURE OF JURY <i>[Signature]</i>		99. SIGNATURE OF CORONER <i>[Signature]</i>		100. SIGNATURE OF WITNESS <i>[Signature]</i>	

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07742

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ind</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Calvert Beach</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Calvert Beach</b>	
c. LENGTH OF STAY IN 1b <b>4 yrs</b>		d. STREET ADDRESS <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>—</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jean MacDonald</b>		4. DATE OF DEATH <b>July 10 1961</b>	
5. SEX <b>F</b>	6. COLOR OF RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1896</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Elger</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Louis D. MacDonald - Calvert Beach, Ind.</b>		Address <b>—</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Uterus</b> 1760 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>13 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 7, 1961</b> to <b>July 10, 1961</b> that (I) (we) last saw the deceased alive on <b>July 7, 1961</b> , and that death occurred at <b>2:14 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Page C. Jett</b>		22b. DATE SIGNED <b>7-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Page C. Jett</b>		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>July 11, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. C. Hackness &amp; Son - Mutual, Ind.</b>		25a. SEC'D BY REGISTRAR <b>—</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	
DATE <b>JUL 12 '61</b>			

07725

1977

M

I

Page 207

2-11-01

Continued from page 206. The results of the analysis of the samples collected from the site are as follows:



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
7752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07743										
Item 7 Film G291 7/24/61 jwk										
1. PLACE OF DEATH a. COUNTY <b>CALVERT</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>North Beach</b> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1439 Euclid St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>FORREST</b> Middle <b>ROBERT</b> Last <b>MULNIX</b>					4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/4/22</b>		9. AGE (In years last birthday) <b>38</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NOVELTY</b>			11. BIRTHPLACE (State or foreign country) <b>POLO ILL</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
13. FATHER'S NAME <b>FORREST ROBERT MULNIX</b>					14. MOTHER'S MAIDEN NAME <b>LAURETTE MURPHY</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES</b> <b>WW II</b>					16. SOCIAL SECURITY NO. <b>332-16-1804</b>		17. INFORMANT <b>W. CHAMBERS, WASH. DC.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty infiltration of liver</b> <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute alcoholism</b>										INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>7/12/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-19-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>				
23. FUNERAL DIRECTOR <b>44 Cook Inc. 1217 St. Paul St.</b>						24a. REC'D BY REGISTRAR <b>JUL 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

DEVLAD

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

• •

08/19/2007

444 18 10 1941

1945-46

4. 1. 1941

7753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07744

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Clifford</u> Last <u>Mundell</u> DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1961</u>				4. DATE OF BIRTH Month <u>July</u> Day <u>7</u> Year <u>1918</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years, not birthday) <u>43</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>W. Beach</u>		<u>W. Beach</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Kiefer Mundell</u>				14. MOTHER'S MAIDEN NAME <u>Wm. E. Kiefer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>1943-1946 577-01-3796</u>		17. INFORMANT <u>H. J. Mundell, W. Beach Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholic poison</u> 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>322.2</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>found dead in bed</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>5:30</u> a.m. <u>p.m.</u> Month, Day, Year <u>7 16 1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>W. Beach Calvert Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) <u>H. W. WARD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-19-61</u>		<u>Urbington National</u>		<u>Urbington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Butchers Funeral Home Owings Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div>Items 18-21 Film 292 8 0 67 1961</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>7754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07745</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Calvert</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Calvert County Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>ISABELLA SMITH</b> First Middle Last <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Colored</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>September 25, 1924</b> <b>9. AGE</b> (In years last birthday) <b>36</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.						<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <b>Phillip Harris</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Nettie Giles</b>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>218-30-4178</b> <b>17. INFORMANT</b> <b>Asbury Smith, Owings Md</b> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of neck with perforation of left carotid artery and transection of spinal cord</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>981X DUE TOX</b> (c) <b>981X DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>Bystander at altercation during which gun was fired</b>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour</b> <b>6:30</b> <b>p.m.</b> <b>7/16/61</b> <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Hilltop</b> <b>20f. (City or town)</b> <b>Owings</b> <b>(County)</b> <b>Calvert</b> <b>(State)</b> <b>Md.</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>Peter W. Rieckert</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <b>Peter W. Rieckert, M.D.</b> <b>M.D. ASSISTANT MEDICAL EXAMINER</b> <b>Associate Pathologist</b> <b>DATE SIGNED</b> <b>7/17/61</b> <b>Address (Street, city, town, or county)</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>7-20-61</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Edmonds</b> <b>22d. LOCATION (City, town, or country)</b> <b>Sunderland-</b> <b>(State)</b> <b>Md</b>											
<b>23. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Linkney E. Sewell, Prince Frederick</b> <b>DATE JUL 24 '61</b> <b>Arthur S. Knead</b>											

MASTERSHIP WITH DEPARTMENT OF HEALTH  
MEDICAL EXAMINATION CERTIFICATE OF DEATH  
1914

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
OFFICIAL USE ONLY: [illegible]

121

TO THE REGISTER GENERAL OF THE DISTRICT OF COLUMBIA

TO THE REGISTER GENERAL OF THE DISTRICT OF COLUMBIA



7755 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07746

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. LENGTH OF STAY IN 1b <b>3 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>E.</b> Last <b>Stafford</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/73</b>		9. AGE (In years lost birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Benjamin Stafford</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Frank Stafford - Barstow, Ind.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>mesenteric thrombosis - Toxicemia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arterio-sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1961</b> to <b>July 29, 1961</b> that (I) (we) last saw the deceased alive on <b>July 29, 1961</b> , and that death occurred at <b>8:55</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>R. De Villarreal</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/29/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. De Villarreal</b>				22d. ADDRESS <b>St Leonard, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 31, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ashbury Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Barstow - Calvert Co., Ind</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. D. Harkness &amp; Son - Mutual, Ind.</b>				25a. REG'D BY REGISTRAR <b>Aug 1 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 07747

7756

1. PLACE OF DEATH a. COUNTY <i>Cabaret</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cabaret</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>510 - 4th Street</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Elizabeth</i> Last <i>Sullivan</i>		4. DATE OF DEATH Month <i>7</i> Day <i>6</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <i>12</i> Year <i>1879</i>
9. AGE (In years (and birthday) yrs. <i>81</i>		IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H W</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>in. own home</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Edward Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Julia Ricketts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs M. E Davis</i>		Address <i>N. Beach Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cigs</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i></i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had diabetes about 12 yrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i></i> Day <i></i> Year <i>19</i> Hour <i>s. m.</i> p. m. <i></i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/6</i> , 19 <i>61</i> , to <i>7/6</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>7/6</i> , 19 <i>61</i> , and that death occurred at <i>3:45</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H W Ward</i> M.D.		ADDRESS (Street, city or town, state) <i>Washington D.C.</i> DATE SIGNED <i>7/6/61</i>	
PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/8/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home, Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 10 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint handwritten name]</p>		<p>2. SEX                  [Faint handwritten sex]</p>	
<p>3. AGE                  [Faint handwritten age]</p>		<p>4. RACE                  [Faint handwritten race]</p>	
<p>5. DATE OF DEATH                  [Faint handwritten date]</p>		<p>6. TIME OF DEATH                  [Faint handwritten time]</p>	
<p>7. PLACE OF DEATH                  [Faint handwritten place]</p>		<p>8. CAUSE OF DEATH                  [Faint handwritten cause]</p>	
<p>9. MANNER OF DEATH                  [Faint handwritten manner]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF REGISTRAR                  [Faint handwritten signature]</p>		<p>12. SIGNATURE OF WITNESS                  [Faint handwritten signature]</p>	

## 7757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07748

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>758 Silver Spring Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Gerald Wayne Thompson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/21</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army mess installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. J. W. Thompson Blue Spring</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW11</u>	
17. INFORMANT <u>Mrs. John P. O'Shea, 1653 N. Meade, Chicago</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hit on left ear &amp; neck</u> 850X DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brown</u> DUE TO <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell off boat and hit by propeller</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fallen from boat &amp; hit ear &amp; neck</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beers Lake N. F. Calvert MCo</u>	
20c. TIME OF INJURY Month, Day, Year <u>7/1/61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>  </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/2/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial 7/10/61</u>		22b. DATE THEREOF <u>7/10/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Acradia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPT. OF MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please see the Medical Examiner's Office. To the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7758

## CERTIFICATE OF DEATH

Reg. Dist. No. 07749

1. PLACE OF DEATH o. COUNTY <b>Calvert</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake Beach</b>	
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>L.</b> Last <b>THORNTON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 14, 1879</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lloyd L. Thornton, Chesapeake Beach, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordiany occlusion</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-20, 1961</b> , to <b>7-27, 1961</b> , that I last saw the deceased alive on <b>7/27, 1961</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Huntingtown, Maryland</b> DATE SIGNED <b>7/27/61</b> ACTUAL SIGNATURE <b>George J. Weems</b> M.D. PHYSICIAN'S NAME (Type) <b>George J. Weems</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 1, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smethport, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home Owings Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 1 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Carley L. Knecht</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07750

1. PLACE OF DEATH a. COUNTY <i>Cabaret</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Georges</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cabaret Hospital</i>		d. STREET ADDRESS <i>Mimosa Cove</i>	
4. NAME OF DECEASED (Type or print) <i>Edith Elizabeth Wheeler</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1895 Nov 16 1895</i>
9. AGE (in years last birthday) <i>62</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13. FATHER'S NAME <i>B. Chandler</i>		14. MOTHER'S MAIDEN NAME <i>W. D. Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Thomas B. Wheeler</i>		Address <i>Deals</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>904.0</i> DUE TO <i>kidney infection following fractured hip</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>fractured hip</i> DUE TO (c) <i>80 days</i>		INTERVAL BETWEEN ONSET AND DEATH <i>80 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>fell and fractured hip 80 days ago</i>			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>fell at home</i>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>May 19 61</i>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20d. (City or town) <i>Deals</i> (County) <i>aa</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7/17/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/20/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DATE JUL 19 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

